

6845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 36 Kingsley Road			
3. NAME OF DECEASED (Type or print) First Lawrence Middle S Last Bell				4. DATE OF DEATH Month June Day 19 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/93		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 6 Days 19 Hours 59 Min.	IF UNDER 24 HRS. Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Thomas Spencer Bell				14. MOTHER'S MAIDEN NAME Rosa Jackson Wyse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. I.				16. SOCIAL SECURITY NO. 212-40-6480		17. INFORMANT W. John L. Bell, Baltimore & Jennifer L. Bell, Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac hypertrophy DUE TO (c) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 8 hrs. unknown						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema; chr. brain synd assoc with cerebral ascl.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	Month June Day 12 Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from June 12 , 19 59 , to June 19 , 19 59 , that I last saw the deceased alive on 6/19/59 , 19 59 , and that death occurred at 10:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 6/19/59							
ACTUAL SIGNATURE Stephen Lee Magness M.D. Ellicott City, Md.							
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hospital, Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial	June 22, 1959	Baltimore, Md.		Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Baltimore, Md.				24. REC'D BY REGISTRAR June 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6846

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b Ellicott City d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 414 Frederick Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IDA ESTELLA BRIGGS		4. DATE OF DEATH Month Day Year June 30, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1871
9. AGE (In years lost birthday) 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Montgomery Co. Md	
11. BIRTHPLACE (State or foreign country) Montgomery Co. Md		12. CITIZEN OF WHAT COUNTRY? Montgomery Co. Md	
13. FATHER'S NAME Richard Burriss		14. MOTHER'S MAIDEN NAME Mary Elizabeth Cracraft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. *	
17. INFORMANT Dudley Zenter, Ellicott City, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic-Hypertensive Cardiac Vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 da. 10 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-10 , 19 58 , to 6-30 , 19 59 that I lost saw the deceased alive on 6-29 , 19 59 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas F. Herbert M.D. 46 Church Road Ellicott City, Md 7-1-59			
ACTUAL SIGNATURE Thomas F. Herbert		PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Rockville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral director. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6847

Items 3,7 FilmG244 7-20-59 et

CERTIFICATE OF DEATH

06839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b X Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waterloo Road				e. STREET ADDRESS Waterloo Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY Middle F. Last DAMM, Jr.				4. DATE OF DEATH Month June Day 2 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 23 1878		9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months 2 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Baltimore Co. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry F. Damm				14. MOTHER'S MAIDEN NAME Barbara Iager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-7710		INFORMANT Address Mrs. Herman Pfeiffer, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Acute pulmonary edema DUE TO (b) Myocardial Insuff DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from June 1, 1958 to June 2, 1959 , that I last saw the deceased alive on June 2, 1959 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Frank E. Shipley M.D. ADDRESS (Street, city or town, state) Savage, Md., 6/2/59 PHYSICIAN'S NAME (Type) Frank E. Shipley 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-1959		22c. NAME OF CEMETERY OR CREMATORY Trinity Chapel		22d. LOCATION (City, town, or county) (State) Pfeiffers Corner, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE JUN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knease	

MEDICAL CERTIFICATION

DECLARATION OF DEATH



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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm		d. STREET ADDRESS 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Fine Last Fine		4. DATE OF DEATH Month June Day 12 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1883
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Lithuania	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Feldman		14. MOTHER'S MAIDEN NAME Freda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Samuel E Fine	
17. INFORMANT Samuel E Fine		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General arteriosclerosis DUE TO (c) General arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 min. years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Associated with cerebral arteriosclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3 , 19 59 , to June 12 , 19 59 , that I last saw the deceased alive on June 12 , 19 59 , and that death occurred at 7:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Taylor Manor Hosp. Ellicott City, Md DATE SIGNED 6/12/59			
ACTUAL SIGNATURE Irving J. Taylor		M.D. Taylor Manor Hosp. Ellicott City, Md	
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.		Taylor Manor Hospital, Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-59	
22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewicki		ADDRESS 2100 Eutaw Place	
24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR OR: After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6849

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodbine			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Frederick Road				d. STREET ADDRESS Old Frederick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUDOLPH M Middle FRINCKE Last				4. DATE OF DEATH Month June Day 16 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Grand Rapids Mich.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Carl A. Frincke				14. MOTHER'S MAIDEN NAME Anna Bierkner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-03-6112		17. INFORMANT Mr. Robert Frincke, Tornado, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 15 min			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George E. Burgtorf M.D. EXAMINER'S NAME (Type) George E. Burgtorf				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED June 15, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-59		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		22d. LOCATION (City, town, or county) (State) So. Charleston, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Elliot City, Md				24a. REC'D BY REGISTRAR DATE JUN 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED George F. [illegible]		SEX Male		AGE 67		DATE OF BIRTH June 15, 1899	
PLACE OF BIRTH [illegible]		OCCUPATION [illegible]		CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]	
RESIDENCE [illegible]		PLACE OF DEATH [illegible]		DATE OF DEATH [illegible]		TIME OF DEATH [illegible]	
NAME OF PHYSICIAN [illegible]		NAME OF ASSISTANT [illegible]		NAME OF WITNESS [illegible]		NAME OF SECOND WITNESS [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF ASSISTANT [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF SECOND WITNESS [illegible]	
CERTIFICATE OF DEATH [illegible]		CERTIFICATE OF DEATH [illegible]		CERTIFICATE OF DEATH [illegible]		CERTIFICATE OF DEATH [illegible]	

THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL RECORD AS KEPT IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND.

[Faint, illegible handwriting throughout the body of the certificate, likely bleed-through from the reverse side.]



6851

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06843

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fruitown Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Simpsonville</u> d. STREET ADDRESS <u>Fruitown Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William C. Kelly</u> First Middle Last 4. DATE OF DEATH <u>June 1, 1959</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 9, 1878</u> 9. AGE (In years last birthday) yrs. <u>80</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Kelly</u> 14. MOTHER'S MAIDEN NAME <u>Emily unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>David T. Kelly</u> 17. INFORMANT <u>Simpsonville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen'l. Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <u>Dental Caries</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>10 Yrs.</u> <u>15 Yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/16, 1959</u> , to <u>6/1, 1959</u> , that I last saw the deceased alive on <u>5/29, 1959</u> , and that death occurred at <u>4:10</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>J. M. Warren Laurel 6/1/59</u> DATE SIGNED			
ACTUAL SIGNATURE <u>J. M. Warren</u> PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6/4/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Laurel</u> 22d. LOCATION (City, town, or county) (State) <u>Simpsonville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sander</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 8 '59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove capstan papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

06822

1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		c. LENGTH OF STAY IN 1b <u>16 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daisy Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Lester</u> Last <u>Knill</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William T. Knill</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Wolfe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>216-12-1460</u>	
17. INFORMANT <u>Mrs. Lester Knill - Woodbine, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1950</u> to <u>1959</u> , that I last saw the deceased alive on <u>May 9, 1959</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		DATE SIGNED <u>6/23/59</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		<u>Mount Airy, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OLK GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>COLENTWOOD Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. HIGGINS</u>		24. REC'D BY REGISTRAR <u>Arthur & Klaus</u>	
ADDRESS <u>130 THOMAS</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Klaus</u>	

00432

CERTIFICATE OF DEATH

1882

1. NAME OF DECEASED <i>John Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1882</i>	
5. PLACE OF BIRTH <i>England</i>		6. OCCUPATION <i>Farmer</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>	
9. NAME OF PHYSICIAN <i>Dr. J. B. Smith</i>		10. NAME OF FUNERAL HOME <i>None</i>		11. NAME OF BURIAL PLACE <i>St. John's Church</i>		12. NAME OF MINISTER <i>Rev. J. B. Smith</i>	
13. NAME OF NEXT OF KIN <i>John Smith</i>		14. NAME OF WITNESS <i>John Smith</i>		15. NAME OF SECOND WITNESS <i>John Smith</i>		16. NAME OF THIRD WITNESS <i>John Smith</i>	
17. NAME OF FOURTH WITNESS <i>John Smith</i>		18. NAME OF FIFTH WITNESS <i>John Smith</i>		19. NAME OF SIXTH WITNESS <i>John Smith</i>		20. NAME OF SEVENTH WITNESS <i>John Smith</i>	
21. NAME OF EIGHTH WITNESS <i>John Smith</i>		22. NAME OF NINTH WITNESS <i>John Smith</i>		23. NAME OF TENTH WITNESS <i>John Smith</i>		24. NAME OF ELEVENTH WITNESS <i>John Smith</i>	
25. NAME OF TWELFTH WITNESS <i>John Smith</i>		26. NAME OF THIRTEENTH WITNESS <i>John Smith</i>		27. NAME OF FOURTEENTH WITNESS <i>John Smith</i>		28. NAME OF FIFTEENTH WITNESS <i>John Smith</i>	
29. NAME OF SIXTEENTH WITNESS <i>John Smith</i>		30. NAME OF SEVENTEENTH WITNESS <i>John Smith</i>		31. NAME OF EIGHTEENTH WITNESS <i>John Smith</i>		32. NAME OF NINETEENTH WITNESS <i>John Smith</i>	
33. NAME OF TWENTIETH WITNESS <i>John Smith</i>		34. NAME OF TWENTY-FIRST WITNESS <i>John Smith</i>		35. NAME OF TWENTY-SECOND WITNESS <i>John Smith</i>		36. NAME OF TWENTY-THIRD WITNESS <i>John Smith</i>	
37. NAME OF TWENTY-FOURTH WITNESS <i>John Smith</i>		38. NAME OF TWENTY-FIFTH WITNESS <i>John Smith</i>		39. NAME OF TWENTY-SIXTH WITNESS <i>John Smith</i>		40. NAME OF TWENTY-SEVENTH WITNESS <i>John Smith</i>	
41. NAME OF TWENTY-EIGHTH WITNESS <i>John Smith</i>		42. NAME OF TWENTY-NINTH WITNESS <i>John Smith</i>		43. NAME OF THIRTIETH WITNESS <i>John Smith</i>		44. NAME OF THIRTY-FIRST WITNESS <i>John Smith</i>	
45. NAME OF THIRTY-SECOND WITNESS <i>John Smith</i>		46. NAME OF THIRTY-THIRD WITNESS <i>John Smith</i>		47. NAME OF THIRTY-FOURTH WITNESS <i>John Smith</i>		48. NAME OF THIRTY-FIFTH WITNESS <i>John Smith</i>	
49. NAME OF THIRTY-SIXTH WITNESS <i>John Smith</i>		50. NAME OF THIRTY-SEVENTH WITNESS <i>John Smith</i>		51. NAME OF THIRTY-EIGHTH WITNESS <i>John Smith</i>		52. NAME OF THIRTY-NINTH WITNESS <i>John Smith</i>	
53. NAME OF FORTY WITNESS <i>John Smith</i>		54. NAME OF FORTY-FIRST WITNESS <i>John Smith</i>		55. NAME OF FORTY-SECOND WITNESS <i>John Smith</i>		56. NAME OF FORTY-THIRD WITNESS <i>John Smith</i>	
57. NAME OF FORTY-FOURTH WITNESS <i>John Smith</i>		58. NAME OF FORTY-FIFTH WITNESS <i>John Smith</i>		59. NAME OF FORTY-SIXTH WITNESS <i>John Smith</i>		60. NAME OF FORTY-SEVENTH WITNESS <i>John Smith</i>	
61. NAME OF FORTY-EIGHTH WITNESS <i>John Smith</i>		62. NAME OF FORTY-NINTH WITNESS <i>John Smith</i>		63. NAME OF FIFTIETH WITNESS <i>John Smith</i>		64. NAME OF FIFTY-FIRST WITNESS <i>John Smith</i>	
65. NAME OF FIFTY-SECOND WITNESS <i>John Smith</i>		66. NAME OF FIFTY-THIRD WITNESS <i>John Smith</i>		67. NAME OF FIFTY-FOURTH WITNESS <i>John Smith</i>		68. NAME OF FIFTY-FIFTH WITNESS <i>John Smith</i>	
69. NAME OF FIFTY-SIXTH WITNESS <i>John Smith</i>		70. NAME OF FIFTY-SEVENTH WITNESS <i>John Smith</i>		71. NAME OF FIFTY-EIGHTH WITNESS <i>John Smith</i>		72. NAME OF FIFTY-NINTH WITNESS <i>John Smith</i>	
73. NAME OF SIXTIETH WITNESS <i>John Smith</i>		74. NAME OF SIXTY-FIRST WITNESS <i>John Smith</i>		75. NAME OF SIXTY-SECOND WITNESS <i>John Smith</i>		76. NAME OF SIXTY-THIRD WITNESS <i>John Smith</i>	
77. NAME OF SIXTY-FOURTH WITNESS <i>John Smith</i>		78. NAME OF SIXTY-FIFTH WITNESS <i>John Smith</i>		79. NAME OF SIXTY-SIXTH WITNESS <i>John Smith</i>		80. NAME OF SIXTY-SEVENTH WITNESS <i>John Smith</i>	
81. NAME OF SIXTY-EIGHTH WITNESS <i>John Smith</i>		82. NAME OF SIXTY-NINTH WITNESS <i>John Smith</i>		83. NAME OF SEVENTIETH WITNESS <i>John Smith</i>		84. NAME OF SEVENTY-FIRST WITNESS <i>John Smith</i>	
85. NAME OF SEVENTY-SECOND WITNESS <i>John Smith</i>		86. NAME OF SEVENTY-THIRD WITNESS <i>John Smith</i>		87. NAME OF SEVENTY-FOURTH WITNESS <i>John Smith</i>		88. NAME OF SEVENTY-FIFTH WITNESS <i>John Smith</i>	
89. NAME OF SEVENTY-SIXTH WITNESS <i>John Smith</i>		90. NAME OF SEVENTY-SEVENTH WITNESS <i>John Smith</i>		91. NAME OF SEVENTY-EIGHTH WITNESS <i>John Smith</i>		92. NAME OF SEVENTY-NINTH WITNESS <i>John Smith</i>	
93. NAME OF EIGHTIETH WITNESS <i>John Smith</i>		94. NAME OF EIGHTY-FIRST WITNESS <i>John Smith</i>		95. NAME OF EIGHTY-SECOND WITNESS <i>John Smith</i>		96. NAME OF EIGHTY-THIRD WITNESS <i>John Smith</i>	
97. NAME OF EIGHTY-FOURTH WITNESS <i>John Smith</i>		98. NAME OF EIGHTY-FIFTH WITNESS <i>John Smith</i>		99. NAME OF EIGHTY-SIXTH WITNESS <i>John Smith</i>		100. NAME OF EIGHTY-SEVENTH WITNESS <i>John Smith</i>	
101. NAME OF EIGHTY-EIGHTH WITNESS <i>John Smith</i>		102. NAME OF EIGHTY-NINTH WITNESS <i>John Smith</i>		103. NAME OF NINETY WITNESS <i>John Smith</i>		104. NAME OF NINETY-FIRST WITNESS <i>John Smith</i>	
105. NAME OF NINETY-SECOND WITNESS <i>John Smith</i>		106. NAME OF NINETY-THIRD WITNESS <i>John Smith</i>		107. NAME OF NINETY-FOURTH WITNESS <i>John Smith</i>		108. NAME OF NINETY-FIFTH WITNESS <i>John Smith</i>	
109. NAME OF NINETY-SIXTH WITNESS <i>John Smith</i>		110. NAME OF NINETY-SEVENTH WITNESS <i>John Smith</i>		111. NAME OF NINETY-EIGHTH WITNESS <i>John Smith</i>		112. NAME OF NINETY-NINTH WITNESS <i>John Smith</i>	
113. NAME OF HUNDRED WITNESS <i>John Smith</i>		114. NAME OF HUNDRED-FIRST WITNESS <i>John Smith</i>		115. NAME OF HUNDRED-SECOND WITNESS <i>John Smith</i>		116. NAME OF HUNDRED-THIRD WITNESS <i>John Smith</i>	
117. NAME OF HUNDRED-FOURTH WITNESS <i>John Smith</i>		118. NAME OF HUNDRED-FIFTH WITNESS <i>John Smith</i>		119. NAME OF HUNDRED-SIXTH WITNESS <i>John Smith</i>		120. NAME OF HUNDRED-SEVENTH WITNESS <i>John Smith</i>	
121. NAME OF HUNDRED-EIGHTH WITNESS <i>John Smith</i>		122. NAME OF HUNDRED-NINTH WITNESS <i>John Smith</i>		123. NAME OF HUNDRED-TENTH WITNESS <i>John Smith</i>		124. NAME OF HUNDRED-ELEVENTH WITNESS <i>John Smith</i>	
125. NAME OF HUNDRED-TWELFTH WITNESS <i>John Smith</i>		126. NAME OF HUNDRED-THIRTEENTH WITNESS <i>John Smith</i>		127. NAME OF HUNDRED-FOURTEENTH WITNESS <i>John Smith</i>		128. NAME OF HUNDRED-FIFTEENTH WITNESS <i>John Smith</i>	
129. NAME OF HUNDRED-SIXTEENTH WITNESS <i>John Smith</i>		130. NAME OF HUNDRED-SEVENTEENTH WITNESS <i>John Smith</i>		131. NAME OF HUNDRED-EIGHTEENTH WITNESS <i>John Smith</i>		132. NAME OF HUNDRED-NINETEENTH WITNESS <i>John Smith</i>	
133. NAME OF HUNDRED-TWENTIETH WITNESS <i>John Smith</i>		134. NAME OF HUNDRED-TWENTY-FIRST WITNESS <i>John Smith</i>		135. NAME OF HUNDRED-TWENTY-SECOND WITNESS <i>John Smith</i>		136. NAME OF HUNDRED-TWENTY-THIRD WITNESS <i>John Smith</i>	
137. NAME OF HUNDRED-TWENTY-FOURTH WITNESS <i>John Smith</i>		138. NAME OF HUNDRED-TWENTY-FIFTH WITNESS <i>John Smith</i>		139. NAME OF HUNDRED-TWENTY-SIXTH WITNESS <i>John Smith</i>		140. NAME OF HUNDRED-TWENTY-SEVENTH WITNESS <i>John Smith</i>	
141. NAME OF HUNDRED-TWENTY-EIGHTH WITNESS <i>John Smith</i>		142. NAME OF HUNDRED-TWENTY-NINTH WITNESS <i>John Smith</i>		143. NAME OF HUNDRED-THIRTIETH WITNESS <i>John Smith</i>		144. NAME OF HUNDRED-THIRTY-FIRST WITNESS <i>John Smith</i>	
145. NAME OF HUNDRED-THIRTY-SECOND WITNESS <i>John Smith</i>		146. NAME OF HUNDRED-THIRTY-THIRD WITNESS <i>John Smith</i>		147. NAME OF HUNDRED-THIRTY-FOURTH WITNESS <i>John Smith</i>		148. NAME OF HUNDRED-THIRTY-FIFTH WITNESS <i>John Smith</i>	
149. NAME OF HUNDRED-THIRTY-SIXTH WITNESS <i>John Smith</i>		150. NAME OF HUNDRED-THIRTY-SEVENTH WITNESS <i>John Smith</i>		151. NAME OF HUNDRED-THIRTY-EIGHTH WITNESS <i>John Smith</i>		152. NAME OF HUNDRED-THIRTY-NINTH WITNESS <i>John Smith</i>	
153. NAME OF HUNDRED-FORTY WITNESS <i>John Smith</i>		154. NAME OF HUNDRED-FORTY-FIRST WITNESS <i>John Smith</i>		155. NAME OF HUNDRED-FORTY-SECOND WITNESS <i>John Smith</i>		156. NAME OF HUNDRED-FORTY-THIRD WITNESS <i>John Smith</i>	
157. NAME OF HUNDRED-FORTY-FOURTH WITNESS <i>John Smith</i>		158. NAME OF HUNDRED-FORTY-FIFTH WITNESS <i>John Smith</i>		159. NAME OF HUNDRED-FORTY-SIXTH WITNESS <i>John Smith</i>		160. NAME OF HUNDRED-FORTY-SEVENTH WITNESS <i>John Smith</i>	
161. NAME OF HUNDRED-FORTY-EIGHTH WITNESS <i>John Smith</i>		162. NAME OF HUNDRED-FORTY-NINTH WITNESS <i>John Smith</i>		163. NAME OF HUNDRED-FIFTIETH WITNESS <i>John Smith</i>		164. NAME OF HUNDRED-FIFTY-FIRST WITNESS <i>John Smith</i>	
165. NAME OF HUNDRED-FIFTY-SECOND WITNESS <i>John Smith</i>		166. NAME OF HUNDRED-FIFTY-THIRD WITNESS <i>John Smith</i>		167. NAME OF HUNDRED-FIFTY-FOURTH WITNESS <i>John Smith</i>		168. NAME OF HUNDRED-FIFTY-FIFTH WITNESS <i>John Smith</i>	
169. NAME OF HUNDRED-FIFTY-SIXTH WITNESS <i>John Smith</i>		170. NAME OF HUNDRED-FIFTY-SEVENTH WITNESS <i>John Smith</i>		171. NAME OF HUNDRED-FIFTY-EIGHTH WITNESS <i>John Smith</i>		172. NAME OF HUNDRED-FIFTY-NINTH WITNESS <i>John Smith</i>	
173. NAME OF HUNDRED-SIXTIETH WITNESS <i>John Smith</i>		174. NAME OF HUNDRED-SIXTY-FIRST WITNESS <i>John Smith</i>		175. NAME OF HUNDRED-SIXTY-SECOND WITNESS <i>John Smith</i>		176. NAME OF HUNDRED-SIXTY-THIRD WITNESS <i>John Smith</i>	
177. NAME OF HUNDRED-SIXTY-FOURTH WITNESS <i>John Smith</i>		178. NAME OF HUNDRED-SIXTY-FIFTH WITNESS <i>John Smith</i>		179. NAME OF HUNDRED-SIXTY-SIXTH WITNESS <i>John Smith</i>		180. NAME OF HUNDRED-SIXTY-SEVENTH WITNESS <i>John Smith</i>	
181. NAME OF HUNDRED-SIXTY-EIGHTH WITNESS <i>John Smith</i>		182. NAME OF HUNDRED-SIXTY-NINTH WITNESS <i>John Smith</i>		183. NAME OF HUNDRED-SEVENTIETH WITNESS <i>John Smith</i>		184. NAME OF HUNDRED-SEVENTY-FIRST WITNESS <i>John Smith</i>	
185. NAME OF HUNDRED-SEVENTY-SECOND WITNESS <i>John Smith</i>		186. NAME OF HUNDRED-SEVENTY-THIRD WITNESS <i>John Smith</i>		187. NAME OF HUNDRED-SEVENTY-FOURTH WITNESS <i>John Smith</i>		188. NAME OF HUNDRED-SEVENTY-FIFTH WITNESS <i>John Smith</i>	
189. NAME OF HUNDRED-SEVENTY-SIXTH WITNESS <i>John Smith</i>		190. NAME OF HUNDRED-SEVENTY-SEVENTH WITNESS <i>John Smith</i>		191. NAME OF HUNDRED-SEVENTY-EIGHTH WITNESS <i>John Smith</i>		192. NAME OF HUNDRED-SEVENTY-NINTH WITNESS <i>John Smith</i>	
193. NAME OF HUNDRED-EIGHTIETH WITNESS <i>John Smith</i>		194. NAME OF HUNDRED-EIGHTY-FIRST WITNESS <i>John Smith</i>		195. NAME OF HUNDRED-EIGHTY-SECOND WITNESS <i>John Smith</i>		196. NAME OF HUNDRED-EIGHTY-THIRD WITNESS <i>John Smith</i>	
197. NAME OF HUNDRED-EIGHTY-FOURTH WITNESS <i>John Smith</i>		198. NAME OF HUNDRED-EIGHTY-FIFTH WITNESS <i>John Smith</i>		199. NAME OF HUNDRED-EIGHTY-SIXTH WITNESS <i>John Smith</i>		200. NAME OF HUNDRED-EIGHTY-SEVENTH WITNESS <i>John Smith</i>	

1882

1

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS. IT IS NOT TO BE LOANED, COPIED, OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6853

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06844

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b X Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Frederick Road				d. STREET ADDRESS Old Frederick Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First COURTNEY Middle B. Last KOONTZ				4. DATE OF DEATH Month June Day 5 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1912		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cloth Finisher		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leslie G. Koontz				14. MOTHER'S MAIDEN NAME Estelle Sisk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-6042		17. INFORMANT Address Mrs. Frances Koontz, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial asthma, chronic DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. p. m. <input type="checkbox"/> Not while o. m. p. m. <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1958 to June 5, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 11 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md DATE SIGNED _____ ACTUAL SIGNATURE Robert B Taylor M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-59		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE JUN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6854

CERTIFICATE OF DEATH

06845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harvard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harvard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Laurel</u>		c. LENGTH OF STAY IN TB <u>5 years</u> x <u>North Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Overman</u> Last		4. DATE OF DEATH June 26 1959	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1908</u> 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Manila, Arkansas</u>
13. FATHER'S NAME <u>Vallie A. Thaman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Miezell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lawrence Overman, Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of sigmoid, eschismic.</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma of bowel, lungs.</u> (c) <u>Metastatic carcinoma.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-24</u> , 19 <u>58</u> , to <u>6-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>59</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Idolo Piersandrei</u> M.D.			
PHYSICIAN'S NAME (Type) <u>IDOLO PIERANDREI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>June 28, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>St Pauls Cem</u>		<u>Bullton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Davidson Laurel, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Fraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ilchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's College Swimming Pool		d. STREET ADDRESS Horseshoe Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stanley Middle Peugh Last Jr		4. DATE OF DEATH Month June Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 7, 1945
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months 14 Days 13 Hours 13 Min.	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY? Ellicott City, Md	
13. FATHER'S NAME Stanley Peugh		14. MOTHER'S MAIDEN NAME Clister Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Stanley Peugh, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 929.4 DUE TO (c) 929.4			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) drowned			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) drowned	
20c. TIME OF INJURY Month, Day, Year Hour 9:13 P. M. 6/13 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) swimming pool		20f. (City or town) (County) (State) Ilchester Howard Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-17-59	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS Ellicott City, Md	
24a. REC'D BY REGISTRAR JUN 18 1959		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

6856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Mead - Route 40		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Mead - Route 40	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Long View Dr. & Greenway Dr.		d. STREET ADDRESS Long View Dr. & Greenway Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RODGER Middle H. Last PIPPEN		4. DATE OF DEATH Month June Day 8 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1888
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sports Editor Balto. News		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Pippen		14. MOTHER'S MAIDEN NAME Bertie Hamill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-09-7201	
17. INFORMANT Mrs. Nell S. Pippen - Long View Dr. & Greenway		Address Valley Mead-Route 40	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) Carcinoma of liver.		INTERVAL BETWEEN ONSET AND DEATH Immediate 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1957 , to June 8, 1959 , that I last saw the deceased alive on June 6, 1959 , and that death occurred at 4 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Hassaway M.D.		ADDRESS (Street, city or town, state) Collicott City, Md.	
DATE SIGNED 6/8/59			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor & Sons - Balto.		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2220

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1900"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "10-20-1945"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Md."]	



RECEIVED

NOV 1 1945

6857

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 HANOVER RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS J TAYLOR SR.		4. DATE OF DEATH Month Day Year JUNE 4, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1884
9. AGE (In years last day) 74		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Archit.		10b. KIND OF BUSINESS OR INDUSTRY Newfoundland	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Francis W. Taylor		14. MOTHER'S MAIDEN NAME MARY Susanna French	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Berta H. Taylor, 139 Hanover Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 158.3 DUE TO General Atherosclerosis and dilatation of Aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 mo 3 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 1958 , to June 4, 1959 , that I last saw the deceased alive on June 4, 1959 , and that death occurred at 10:38 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3609 Main St ElkrIDGE, Md. DATE SIGNED 6/5/59			
ACTUAL SIGNATURE B B Brumbaugh M.D.		PHYSICIAN'S NAME (Type) B B Brumbaugh	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/6/59	22c. NAME OF CEMETERY OR CREMATORY Grace Esp.	22d. LOCATION (City, town, or county) (State) ElkrIDGE, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR DATE JUN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Howard H. Hubbard #107 Wilkens Ave.
Burlingame, Md.

Burlingame, Md.

Berta H. Taylor, 139 Hanover Rd.

Francis W. Taylor

Maria Susanna French

Arch.

Newfoundland

US

MALE

WHITE

Oct. 12, 1884

74

FRANCIS J TAYLOR SR.

JUNE 4, 1882

139 HANOVER RD

139 HANOVER RD

BURLINGAME

BURLINGAME

HOWARD

MD

HOWARD

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups Rural			c. LENGTH OF STAY IN 1b X			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mission Road				d. STREET ADDRESS Mission Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last IRISH MICHELL THOMAS				4. DATE OF DEATH Month Day Year 6-24-59 19			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-59		9. AGE (In years last birthday) yrs. Months Days 2 10		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Jessups, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Allen Eugene Thomas				14. MOTHER'S MAIDEN NAME Sarah Ellen Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Sarah E. Thomas, Jessups, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 Infectious Diarrhea DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity and Dehydration							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>George E. Burgtorf</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-59		22c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel		22d. LOCATION (City, town, or county) (State) Highland Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE JUN 26 '59		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hines</i>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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WOODRUFF, L. 1949.

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Figure 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6859

CERTIFICATE OF DEATH

06850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waterloo Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence M. Turner</u> First Middle Last		4. DATE OF DEATH <u>June 6 1959</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 27 83</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edw. J. Turner</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Faith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Grace E. Turner</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6, 1959</u> to <u>June 6, 1959</u> , that I last saw the deceased alive on <u>June 6, 1959</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>4/8/59</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 610 59</u>		22b. DATE THEREOF <u>610 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don 28</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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Page 4
TO HOSPITAL CONTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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6860

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b Ellicott City d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Alice Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 5 Alice Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last TIMOTHY CLYDE WATKINS		4. DATE OF DEATH Month Day Year June 16 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1952
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Herbert Oliver Watkins	
14. MOTHER'S MAIDEN NAME Elisabeth Steep		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT Address Herbert B. Watkins, Ellicott City, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic lung cancer DUE TO (b) Wilm's tumor, right kidney Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 8 mo. 18 mo.	
21. I certify that I attended the deceased from April , 19 58 , to June 16 , 19 59 , that I last saw the deceased alive on June 15 , 19 59 , and that death occurred at 11 A. M, from the causes and on the date stated above. ACTUAL SIGNATURE Donald E. Fisher M.D. PHYSICIAN'S NAME (Type) DONALD E. FISHER M.D. ELLICOTT CITY MD.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> ADDRESS (Street, city or town, state) 676-59 DATE SIGNED 6-16-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

U.S. Department of Health, Education and Welfare

Form 100-10

Washington, D.C.

6-18-59

U.S. Department of Health, Education and Welfare

U.S. Department of Health, Education and Welfare

U.S. Department of Health, Education and Welfare

U.S. Department of Health, Education and Welfare

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U.S. Department of Health, Education and Welfare

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U.S. Department of Health, Education and Welfare

U.S. Department of Health, Education and Welfare

6861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Laural</u>				c. LENGTH OF STAY IN 1b <u>67yr</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL Laural</u>				d. STREET ADDRESS <u>1 Scaggerville Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Scaggerville Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Viola Suffonia Whitehead</u>				4. DATE OF DEATH Month Day Year <u>June 1 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1891</u>	
9. AGE (In years last birthday) <u>67 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Out Home</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Green</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bryant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Walter Whitehead</u> Address <u>Scaggsville Rd, Laurel Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>59</u> , to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert S. McCeney, M.D.</u> <u>6/1/59</u> 402 MAIN ST. LAUREL, MD.							
ACTUAL SIGNATURE <u>Robert S. McCeney</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 4, 1959 Emmanuel Cem.</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <u>Scaggsville Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Carlson, Laurel Md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUN 8 '59</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

6862 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R F D</u>				d. STREET ADDRESS <u>R F D</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM I. WIVEL</u>				4. DATE OF DEATH June 2 19 59			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mrs. Elise Murphy, Brookville, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY ATHEROSCLEROSIS</u> (c) <u>underlying</u> DUE TO cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>CHRONIC</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Donald E. Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-2-59</u>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06854

6863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b Elkridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4 Box 340		d. STREET ADDRESS Route 4 Box 340	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JACOB Middle LEWIS Last ZELTMAN		4. DATE OF DEATH Month June Day 19 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1917
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkridge, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob F. Zeltman		14. MOTHER'S MAIDEN NAME Katherine Kraft	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-5605	
17. INFORMANT Mr. Jacob F. Zeltman, Elkridge, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH Instant. 2 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from 6/18/59 , 19__ to 6/19/59 , 19__, that I last saw the deceased alive on 6/18/59 , 19__, and that death occurred at 6/19/59 , 19__, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Savage, Md. DATE SIGNED 6/20/59 ACTUAL SIGNATURE Frank E. Shipley M.D. Savage, Md. PHYSICIAN'S NAME (Type) Frank E. Shipley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran		22d. LOCATION (City, town, or county) (State) Pleiffers Corner, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Niginbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JUN 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

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578 *Journal of Management Inquiry* 16(5)

Keywords: *transformation; organizational change; organizational development; organizational learning; organizational culture*